1994 International Year of the Family
Année internationale de la famille
Año Internacional de la Familia
Международный год семьи
السنة الدولية للاسرة
国际家庭年

Occasional Papers Series, No. 15 1994

The Concept of Family Health

United Nations

Occasional Papers Series, No. 15 1994

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UNITED NATIONS
Vienna, 1994

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The views expressed in this paper are those of the authors and do not necessarily reflect those of the United Nations Secretariat.

CONTENTS

		Page
Introduction		1
I.	**The family life cycle**	3
II.	**Family health**	8
III.	**Indicators of family health**	10
IV.	**Support needs of families and vulnerable families**	13
V.	**Implications of family health for national action**	17
VI.	**Conclusion**	18

Introduction

The General Assembly of the United Nations, in its resolution 44/82 of 8 December 1989, proclaimed 1994 as the International Year of the Family (IYF) with its theme of "Family: resources and responsibilities in a changing world". The forty-sixth World Health Assembly, in 1993, adopted resolution WHA46.27, which *inter alia* urged all Member States "to give effect to the objectives of the International Year of the Family ... including the strengthening of intersectoral collaboration ... as a crucial means for meeting the health and other development needs of families". The resolution also urged the Director-General of WHO:

> "(1) To provide coordinated support ... for research on methods for measuring and evaluating the effects of policies and programmes on the health and functioning of the family and its members, and for determining which families are at risk of not being able to provide for the basic needs of their members;
>
> "(2) To examine the cost and benefits and social implications of a greater involvement of the family in health promotion, disease prevention, treatment and rehabilitation, with particular emphasis on equity and on sharing of family responsibilities."

At the ninety-third session of the Executive Board, held in 1994, particular note was taken of IYF and it was suggested that the Board should consider submitting to the World Health Assembly a resolution promoting the concept of family health as a programmatic approach at the country level. The resolution should also emphasize that the family should be regarded as the cornerstone of any population policy, and should stress the need to strengthen inter-agency and intersectoral collaboration at the country level.

Describing the family and its functions

In 1990, rather than attempting to define the concept of the family, the Human Rights Committee, in commenting on article 23 of the International Covenant on Civil and Political Rights, noted that the concept of the family might differ in some respects from State to State, and even from region to region within a State, and that it was therefore not possible to give the concept a standard definition. However, the Committee emphasized that when a group of persons was regarded as a family under the legislation and practice of a State, it must be given the protection referred to in article 23.

The family, irrespective of its diverse forms, is recognized as the social unit upon which societies are built and maintained. It has been described as the natural bridge between the individual and society, and is recognized as the proper setting for mutual love, support and companionship of spouses, as the primary determinant of the survival of the children born into it, as the first agent for the socialization of future generations, and in many societies as the only institution of support for the aged. Functions of the family include meeting the basic needs of its members for health, nutrition, shelter, physical and emotional care and personal individual development, as well as the maintenance of family morale and the customs, values and beliefs of the family's culture. Historically, societies have evolved various patterns of family structure for social and economic functions. In pre-industrial societies a great concordance evolved between these functions, with many of the health, developmental and socialization functions taking place first within the family and then within the immediate community. Because there are so many different kinds of family, the concept of family health is often difficult to work with, to describe and for some even to accept. Yet with the decline in the prevalence of traditional family stereotypes (the tribe, the extended family etc.) has come an increasing understanding of the social, psychological and biological coherence of the family and its importance. Families share

a great deal more than their genes. They share their lifestyles, their intimate and extended environment, often their occupational environment, their diet and exercise patterns and nearly always their infecting and symbiotic organisms. Above all, they share their social environment, its vital roles and relationships, its pressures and pleasures, modes of conduct, value systems, sexual behaviour, mores and beliefs.

In ensuring the well-being of the family and society, both families and Governments perform tasks that are interrelated in the areas of health, education, income maintenance, social services, employment and housing. Poverty becomes one of the most important pervading and undermining influences on these relationships. Economic production from agriculture that has been centred in the family and could accommodate such other functions as child rearing and care giving. The mobility required with the shift to urban-centred industrialized economies has put a strain on these functions, particularly on women who now bear the double burden of the demands of economic activity and caring and rearing functions. The family's responsibility has shifted to preparing individuals to be receptive to change and to value the acquisition of the knowledge and skills necessary for economic production outside the family.

The concept of community and family partnership in some family functions has recently been reviewed in the area of early child health and education [8]. Health services and parents share responsibility for the prevention and clinical management of mild childhood illnesses [12], and through programmes for early child care and education. A child's development and educational potential is more likely to be realized by a combination of day care and in-home reinforcement by transferring knowledge to, and strengthening the child-care and stimulation skills of, the parents and particularly the mother.

Childhood and adolescence are critical times for the acquisition of coping and social skills. This process is dependent on having positive attachments, the opportunity and resources to learn the skills and an absence of overwhelming stressful situations. However, the contrary also holds true. The lack of social and coping skills is too readily transmitted to the next generation, particularly where families offer low quality and inconsistent support to children; provide poor behavioural models for substance abuse; lack closeness and involvement in their children's activities; have low educational aspirations; exert weak control and discipline; and are emotionally, physically or sexually abusive of their children. One form of response has been for children to take to the streets where the other street children provide a sense of belonging to a new and often more caring replacement "family". For these young people, the street has become their habitual abode and their families are not a source of primary support. Depending on the definition used, estimates of the numbers of children and young people affected vary widely, with the majority in the developing countries. Childhope, a non-governmental organization, estimates that there are 40 million street children in Latin America, 25-30 million in Asia and 10 million in Africa.

I. The family life cycle

The family can be described from several analytical perspectives: the type of family; the stages of the family life cycle; and in terms of such essential demographic descriptors as size and age characteristics. Of the different dimensions used in describing the family, the family life cycle concept appears to be particularly useful in providing a framework for understanding the dynamics of how the family *per se* affects the health and well-being of its members and how the health and well-being of its members affect the health of the family.

Just as the health of individuals is seen against the life-cycle phases of dependency, growth, maturation, independence and, ultimately, deterioration, so too must the functions of the family be viewed in relation to the stages of its own life cycle. Several family life cycle models have been reviewed by the World Health Organization (WHO) [10]. For the purposes of research on the demography of family life cycles and their health implications, and to exploit the potential availability of cross-sectional data from census or household surveys, six phases of the nuclear family life cycle have been proposed [24]. These are described as:

(a) Formation;

(b) Extension;

(c) Completed extension;

(d) Contraction;

(e) Completed contraction;

(f) Dissolution.

In order to be useful in developing family health programmes, the family life-cycle model must be adapted and modified to reflect the variations both within the model and between societies. Depending on the purposes to which the model is applied, the number of stages can be either reduced or expanded. For example, additional stages or sub-stages could be inserted to reflect the age of children or other events, such as retirement. Based on the time when the oldest child is found in a particular age category, Duval provides a somewhat expanded family life-cycle model [7], which includes:

- Beginning families (married couples or couples in union without children)
- Child-bearing families (oldest child under 30 months)
- Families with children of pre-school age (oldest child 30 months to 6 years)
- Families with schoolchildren (oldest child 6 to 13 years)
- Families with teenagers (oldest child 13 to 20 years)
- Families as "launching centres" (from the time the first child leaves until the last has left)
- Families in the middle years (from "empty nest" to retirement)
- Ageing families (from retirement to the death of both spouses) [12].

The present model does not accommodate the changing family patterns of such a phenomenon as reconstituted families, such as those resulting from the divorce or death and the remarriage of the spouse(s); families that begin with child bearing and may not have a stable male presence, at least initially; families that for voluntary or involuntary reasons remain childless; or the extension of the family when grandparents or other older relatives are incorporated into the immediate family structure. The status of a woman will change according to the stage reached in the family life cycle. The daughter-in-law becomes a mother and, ultimately, the mother-in-law.

An example of how the concept of family life cycles can be adapted to such circumstances is found in the West Indies where the marriage patterns do not correspond to the norm found in most industrialized countries. Three types of unions are recognized in the West Indies:

- A married union (two persons living together and legally married)
- A common-law union (two persons living together but not legally married)
- The visiting union (two persons neither living together nor legally married) [9].

The passage through each phase of the family life cycle produces major family events and, at times, disturbances that are often of a severity that could affect the health of one or other family member. They are usually transitional and include such episodes as marriage, birth of the first child, retirement due to age or illness, transient diseases and bereavement. Other crises, while closely related to family life-cycle stages, do not arise from the family life-cycle stage *per se*. These include such events as death and handicap, divorce, chronic illness, alcoholism and other substance misuse, unemployment and the enforced institutionalization of a family member.

The failure to lay the foundation during one stage for the responsibilities and needs occurring at subsequent stages may result in stress, and conflict and deterioration in the functioning of the family in subsequent stages. Lack of preparation and means for planning parenthood has an adverse multiplier effect throughout the family life cycle, affecting parents and children. The immediate consequences of unwanted pregnancies are seen in the 50-to-60-million-induced abortions each year, nearly half of which are performed under unsafe conditions with consequent mortality and morbidity. The long-term effects of bearing an unwanted child are expressed in a wide spectrum of morbidities and even mortality, including child abuse and neglect; increased morbidity; the phenomenon of street children; impairment in socialization, language development, self-esteem and school performance; and may carry over into the next family generation with marital difficulties [4]. Even when marital harmony exists in the first life-cycle stage of formation and the pregnancy is wanted, there is a deterioration in marital harmony in a significant number of couples within a year of the birth of the first child [14].

Family structure in a changing world

The most commonly used terms to describe family structure include: the extended family, usually led by the elder male spouse and including the households of male offspring; the nuclear family, consisting of parents and their children; and other family forms that include single-parent-headed families or households, cohabitation and consensual unions. Joint and stem families are variants on the extended family, which also may be characterized as three-generational. Concern is expressed in many societies with what is perceived as the replacement of family structures that do not reflect the perceived norm; namely, the shift from extended to nuclear, and from nuclear to single-parent-headed families and alternative family forms.

Single-parent families now account for nearly 20 to 30 per cent of all families in Africa, Latin America and the Caribbean, and for about 15 per cent in Asia and the Pacific [18]. Ninety per cent of them are headed by women and are often concentrated among the poorest and most disadvantaged sections of the population. Single-parent families also arise as a result of war, migration and hunger. In refugee and other situations of population displacement due to conflict, inadequate attention is paid both in policy and operational terms to ensuring that the integrity of the family is maintained. Studies of children's responses to extreme violence, death, abuse or hunger indicate that they are able to resist emotional stress and physical hardship as long as they remain with their families and parents [3]. Emergencies become significant as soon as separations occur and the child's primary attachments are disrupted.

As an independent unit of production, the joint or extended family provides a secure labour force and an established system for tenure and inheritance. The division of labour within traditional family structures, particularly where there is low geographic mobility, is not primarily

based on skill or education but according to sex, age and family status. Decision-making in the family's social and economic life is made by the male head of the household, while the private world of the home is the woman's domain.

Economic development, the demand for labour or perceptions of opportunities, and change, resulting in the mobility and migration of individuals and families, have profound effects on the structure, relationships in, and functions of, the family. On the one hand, there is a greater receptivity to change and adoption of beneficial technologies and institutions, including those of the health and education sectors, while on the other hand such change is associated with a decline in traditional community disciplines, erosion of the cultural norms, particularly among the young, and a lessening of the social and cultural bonds that help maintain community self-reliance [5].

In response to economic imperatives, changing value systems and family planning, the majority of families in most regions of the world are smaller and there is an increasing trend towards nuclear families. The nuclear family is nowadays more often geographically isolated from its relatives than formerly. More children survive than die, older family members are much older and the proportion of the old and the very old is rising. Isolation and ageing are calling into question traditional roles, straining ties of affection and generally distorting family functions. While this pattern may not yet characterize many developing countries, it is becoming apparent in them, and even the assumption that the extended family model serves as the basic model for the rural areas of developing countries no longer holds true universally. The rapid social changes of both the industrial and information revolutions have changed drastically the functions of the family, particularly its older members, and have shifted many of the health, developmental and social functions to non-family institutions, from which families are often excluded or marginalized.

Gender roles are initiated within the family but are derived from and are parallel to those within the society. They determine the distribution of power and influence within both the family and society. Both within and outside the household, the system of gender relationships include sexual relations between adults, division of labour and gender socialization. These relationships not only affect such health issues as sexually transmitted diseases, including the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and violence against women and children, but also the division of health decision-making. Many societies, both modern and traditional, are now paying the price of inequality in negotiating sexual relationships between male and female partners in a family, and the double standard applied to the expression of male sexuality within and outside the family. One expression of this inequity has been that the burden of, and blame for, infertility is placed on women even though up to 40 per cent of infertility may be attributed to a male factor. The term "barrenness" is applied to women, not men. It has strong negative connotations and is the basis of divorce in many traditional societies and religions [23]. Another consequence of the inequality in negotiating sexual relationships in a family has been the increasing burden that AIDS is placing on women and children. The vast majority of women with new HIV infections are monogamous and have acquired the infection from their partners. The inequity must also be measured in terms of the greater risk of HIV transmission from a man to a woman than from a woman to a man. As a consequence, the AIDS epidemic is wiping out hundreds of thousands of families, leaving even more infants and children orphaned, often in the absence of a community support system.

Public health and the advances in medical sciences have contributed to a larger portion of the population living past the age of retirement and economic productivity. In the internationalization of communications and the media, there is an increasing accent on youth, which in part may be contributing to the decline in the prestige of older people as their numbers have increased. In addition, in many industrialized countries, owing to the change in lifestyles and structure of the family, be it a single-parent, divorced or reconstituted family, the reintegration of a surviving grandparent into a family may either be perceived as a burden or a benefit, with the former being the more common. The weight of such a burden depends on a number of factors, both physical and psychological: the degree of dependency of the older family member, space and privacy

considerations, the psychological aspects of the need for the grandparent to exert control, or the amount of security that the younger couple has in their marriage and as parents.

The role of the elderly in the family is also undergoing considerable change in developing countries, particularly with the urban migration of young people and economically active adults. The elder members of the family and clan retain a key role even after their productive role has ended. They play a key role in the socialization and education of the young, as reservoirs of knowledge and wisdom and the providers of information on parenting and sexuality. As noted by Masamba:

> "As older persons become dependent upon the adult and adolescent urban populations because of urban poverty, they ... become vulnerable to being viewed as *ndoki* (those who exercise witchcraft) every time relatives in the city lose their jobs or suffer from any misfortune or illness." [13]

Changing disease patterns

For several decades, a changing disease pattern, referred to as the epidemiologic transition, has become apparent in many countries as a consequence of the extension of health services, increased coverage of immunization and family planning, increased household food security and improvements in housing, water supplies and environmental sanitation. The epidemiological transition encompasses three elements:

(a) That common infectious diseases have begun to be replaced by non-communicable diseases and injuries as the leading cause of death;

(b) That there is a shift in the peak age of morbidity and mortality from the young to the elderly;

(c) That a shift occurs by which there is a greater concern with morbidity and not only with mortality.

This transition is not merely a function of the control of communicable disease. It is also characterized by increased rates of the non-communicable diseases that are associated with: changes in lifestyles, especially use of tobacco, and changes in diet and physical activity; technological developments; and environmental degradation. The fragility of the positive elements of this transition and its dependence on sustained social and economic development in general and health infrastructures in particular is illustrated both in the inequity in health development in many developing countries and in the deterioration noted in many of the States of eastern and central Europe and the republics of the former Soviet Union.

In comparison to the changes in mortality and population experienced in the industrialized countries, the decline in mortality in the middle-income developing countries has taken place in a relatively short period of time. Despite the increased control over infectious diseases, they have not been fully brought under control. Furthermore, the adverse elements of the epidemiologic transition are being accelerated by the very rapid increase in certain lifestyle patterns, some of which are thought to be associated with the internationalization of the media and commercial interests, including the use of tobacco and abuse of alcohol, inappropriate use of infant formula, and increased risk-taking behaviour associated with injury and sexually transmitted diseases. Thus in many countries a process of a double burden of disease is occurring with the coexistence of the diseases of poverty and those of abundance. In a number of countries, both developed and developing, there has been a re-emergence of epidemic diseases such as tuberculosis and diphtheria, once thought to have been eradicated or controlled.

Vulnerability to the burden of disease is increasingly evident throughout the life cycle. As a result of a deterioration in their economic and social circumstances, many countries are experiencing a stagnation or even reversal of what had been a pattern of increasing social involvement in health care. The major burden for care is being either shifted more to the family and community or neglected in the absence of suitable models for support to families and communities in the provision of care.

II. Family health

The idea that there is an entity, family health, which is striven to be achieved and which when achieved is at the very centre of a healthy society, is attractive and may be of value in framing social and fiscal policy, designing services and in allocating priorities in social and medical research.

Thus, good family health is said to be recognizable when the family group itself is physically healthy, happy, productive and efficient in carrying out its tasks – particularly those of protecting, nurturing and socializing the next generation – there is a state of emotional equilibrium between the members of the family group, it serves a number of vital human needs, displays integrity in the face of adversity, resilience and the ability to cope, and so on.

Family health is more than the sum of the health of its individual members. Family health requires that the family itself is healthy, that it provides nurturing, caring and support to its members even when some family members suffer from ill health. Despite such adverse conditions of poverty, displacement and discrimination, some families have a resilience that allows them to meet the essential caring functions. These are families that are highly motivated, draw upon strong value systems and contribute to the health of the individual members with knowledge and skill. Much of the responsibility for such care rests on the women of the family, sometimes to the disadvantage of the girl child whose education may be terminated because of the care demands of the family. As the nuclear family becomes the norm and increasingly women assume the double roles of production and reproduction, they are at higher risks of stress and illness.

The family is one of the most important social contexts within which illness occurs and is resolved, and should serve as a primary unit in health and medical care [15]. It is within the family that an individual is defined as being sick and in which the process is initiated for seeking and utilizing care. Historically, epidemiology and public health have used the terms "family" and "household" interchangeably. While the former has generally been the unit of analysis and been adequate for characterizing the physical environment of disease transmission and acquisition of communicable diseases, it lacks the dynamic focus of the social and behavioural context that the family implies in terms of the role and position of women in the health of the family, dietary patterns and other aspects of lifestyle such as smoking and substance abuse, and the critical family function of caring. The distinction between household and family may not always be important. Yet, an important health variable such as smoking, for example, can be seen in household terms in relation to the consequences of secondary smoking risks, compounded by such variables as crowding. In family terms, smoking would be seen as a parental influence on smoking by children.

The association of mortality and morbidity with changes in the family life-cycle stages has only recently become the subject of research. The effects of life cycle are seen from the first two stages of family formation and extension, affecting such outcomes as low birth weight, and mortality and morbidity among the elderly, particularly during the last stage of family dissolution. While birth weight is closely associated with medical, anthropometric and risk behaviour factors, Ramsey and others have shown that the family function and structure account for 7 and 4 5 per cent of the known variance of birth weight [17]. Lewis has demonstrated the deterioration of marital relationship in one third of couples following the birth of the first child [14], while Berkman and others have shown an increased risk of death in the first six months following a myocardial infarction in the absence of emotional support systems [2].

The role of the home and the family, as opposed to hospitalization, as the locus of care for even serious diseases and terminal illness for the care of children and adults has been widely demonstrated in industrialized countries [1], yet most health systems remain reluctant to recognize the family as a major resource for ensuring a more acceptable and high quality of care from the

perspective of the patient and the family. Such an approach, including the post-operative care following surgery, has been tested in developing countries as well, even in the environments of urban poverty [11]. Not only was the cost of care greatly reduced but also recovery, ambulation and return to normal functions significantly improved.

III. Indicators of family health

If a healthy family is one that carries out its functions with reasonable success within its own culture, then the functional success of the family will be the key to societal health. Yet there are few indicators of family health as distinct from the health of individual members of the family.

> "Despite awareness of the importance of the family unit for personal health conditions and the health care system, the family has ... been infrequently studied from a public health view. ... To a certain extent, the lack of information is due to inadequacies in existing data collection systems, exacerbated by ambiguities in terminology and methodological problems." [20]

The duration of each stage in the family life cycle and family structure serve as two dimensions of a framework for family health indicators. Age at marriage and of first birth already provide a measure of the formation phase of the family life cycle, and provide an indirect indicator of the risks of maternal morbidity and mortality that have a profound impact on the health of other members of the family. The duration of the different stages of the life cycle in 30 countries for the period 1950 to 1970 has been studied by WHO [20]. During this 20-year period, the duration of each stage of the family life cycle increased from 3 to 6 years, mainly due to a decrease in the age of first marriage in countries with low levels of mortality, and to an increase in the duration of the penultimate life-cycle stage of completed family contraction. While these analyses have not been repeated for the period 1970 to 1990, with increasing levels of women in the workforce and their changing role, it might be expected that in some industrialized countries the first stage of family formation would be further prolonged as women delay the bearing of the first child. A significant shift in the number of women bearing their first child at the age of 35 or older would be associated with increased obstetric risks and a demand for medically assisted reproduction. Changes in the duration of family life-cycle stages would also be expected in developing countries, particularly with the changing age of marriage, changes in fertility, entry of larger numbers of women into the workforce and changes in levels of education.

A number of existing indicators of morbidity, mortality, growth and development could also serve as indicators of family health. The physical growth and psychosocial development of young children, being almost entirely dependent on the family environment and care, serves as a positive indicator of family health. With "children by choice, not chance" as a positive goal of family health, contraceptive prevalence serves as a positive indicator (see table 1 below). Recognizing childbearing as one of the central purposes of family formation, involuntary childlessness or infertility are also important indicators of family health.

Mortality or morbidity rates analysed according to marital status provide a measure of family health. Those who are not married, whether single, separated, widowed or divorced, experience higher mortality rates, particularly regarding cardiovascular deaths, than married people, the differential being higher for men than for women [19]. This is true for all causes of mortality together and particularly for cardiovascular deaths. Moreover, the mortality of widowers is greater than that of married men, at least for the first six months after bereavement [2].

Research is needed on methodologies and criteria for measuring and evaluating the impact of policies and programmes on the health, functioning and integrity of the family and its members; and the cost implications of a greater involvement of the family in health promotion, disease prevention, treatment and rehabilitation. A number of efforts have been made to develop indicators of family functioning with respect to health. An example of the family-health implications of a few existing indicators of reproductive health are provided in table 2 below.

Table 1. Reproductive health indicators of family health by geographic region

Region	*Married women who want no more children who are not using any method of contraception (Percentage)*	*Estimated numbers of unsafe abortion per year*	*Reduction of births if those not wanting more children stopped childbearing (Percentage)*
Africa	77	3.3 million	17
Asia	57	10.3 million	33
Europe	-	260,000 (excluding the former republics of the USSR, which are estimated to account for 2.1 million)	-
Latin America and the Caribbean	43	4.6 million	35
Middle East	57	380 000	-

Source: "Monitoring of progress in implementation of strategies for health for all by the year 2000. Third report" (EB95/5).

As concern moves away from medical care (and considerations such as compliance) towards prevention, social care and support systems, it is assumed that knowledge of the family and its persona becomes of even greater importance. However, few well-designed studies support these widely held views, perhaps because so many of them are deemed obvious. From what is known of the dynamics of family life it would also seem obvious that care and support of any kind will benefit the family more if all the relevant details that determine need and response are understood and if the family is treated as a single health unit.

Table 2. Examples of indicators of families for capacity-building efforts

Indicators of families at risk and suitable for action	*Underlying factors or circumstances*	*Effects on family functions*	*Family members affected and way in which they are affected*	*Prevention: policies and programmes at the level of the family and community*	*Treatment or rehabilitation at the level of family/community*
Unwanted birth	Unwanted pregnancy or ambivalence; limited education; lack of social support; lack of information and access to contraception; hostile cultural environment; legal constraints; social position of women	Increased risk of neglect; competition for food and affection within the family; impoverishment of the family; increased infant and child morbidity and mortality	Abandonment of work/education by the mother; increased risk in next pregnancy; competition for scarce household resources; child neglected, abandoned or given up for adoption	Equity in education of girls; capacity of the family for family life and sex education within the family and other institutions; availability and easy access to family planning services; freedom of choice in and diversification of reproductive health services; communication	Creation of social services and legislation to support the family; maternity and paternity leave; child-care services; support programmes for pregnant teenagers to continue school
Low birth weight (LBW)	Teenage pregnancy; substance abuse; short height; poor nutrition during pregnancy and pre-pregnancy; infection; heavy physical work. LBW serves as a more sensitive health indicator of social economic changes than infant mortality	Abandonment (particularly by single women); poor bonding; less breast-feeding; malnutrition at one year of age; increased childhood morbidity and mortality; learning and developmental disorders; increased risk of adult disease (diabetes, hypertension etc.) with increased illness, absenteeism, health-care costs etc.	Infant at increased risk of illness, malnutrition and cognitive and other impairment of development. Mother and other care-givers faced with increased care and nurturing demands. Diversion of care and attention from other children	Equity in health, education and nutrition for the girl child; "peri-conceptual" nutrition; maternity protection legislation and enforcement; increase in the age of first pregnancy	Bonding and breast-feeding: the baby-friendly hospital; mother's social support groups; crèche and early child education

IV. Support needs of families and vulnerable families

It is well established that health is affected by developments in other sectors, and that ill health has repercussions on many other sectors, including education, social welfare, housing, women's affairs, trade, agriculture, employment, criminal justice and the environment. What is less well appreciated is that the locus of these effects often operates within the family setting and that it is within the family that many of the positive interventions promoting health, development and the well-being of individual family members may be most readily applied and integrated. Despite the awareness of these relationships, the family is underutilized. Communities then draw upon other institutions and resources, resulting in a greater fragmentation of responses to health and other developmental needs. All too frequently, the families in greatest need, i.e. those needing support in multiple sectors, slip through the social safety net or are recognized too late, at the point when more costly therapeutic approaches are required. The concept of vulnerable families should be recognized and defined within the health sector and intersectorally so that effective preventive action can be taken. To avoid the stigma that could be attached to the labelling of a family as being at risk, it is preferable to attach the notion of risk to the particular situation that makes the family vulnerable, and to speak of families in hazardous situations.

Responses to stressful events and the ability to cope seem to be determined to a large extent by the quality of relationships within the family reflected in the common patterns to be found in their robustness, their strength, their resilience or in the breakdowns that result. Gross or permanent distortion is relatively uncommon and most families achieve an equilibrium. They are more or less successful in their family relationships. One important response to stressful life events and the strain on the relationships involved can be physical illness and even specific diseases [18], but causal pathways are often unclear.

Some responses are simple and obvious; for example, the support of a sick spouse, more often of husbands by wives, is a key element in the successful control of many acute diseases. This seems to be due to the increased pressure to comply with the prescribed treatment and to provide an ordered, facilitating environment. Another example would be the need of a parent to adhere to a specific diet for a child and the consequent change in the dietary patterns of the whole supportive family. The same is true where an asthmatic child must avoid defined allergens, necessitating a change of internal environment for the whole family.

Divorce and the separation of parents, by threatening secure relationships, have profound effects on the health of the children. These effects are second only to the death of one parent. As noted in a meeting on children and family breakdown held by WHO, the consequences for children depend on their age and stage of development.

> "A family separation immediately after birth can ... be critical. For example, loss of contact with the father in the first years of life can cause identification problems, particularly for boys. Although at this stage family breakdown often causes developmental and behavioural retardation resulting in lasting damage, young children have a remarkable ability to make up for lost ground and in the long term, if the crisis is managed, they will probably show no health deficiencies ... children from three to five years old can exhibit considerable distress through regression, and behavioural and psychological disorders such as aggression, fear and sleeping disorders ... between six and ten, children are more likely to react to family breakdown with sorrow and depression ... amazingly, children at this age can give emotional support to their parents, although they are also susceptible to parental manipulation." [20, 21]

Illness and the dependency of grandparents place a particular stress on the nuclear family. The need to care for elderly relatives, often living in a separate household, can also cause stress especially if associated with feelings of guilt for past neglect. Poorer families may not be able to

take care of their elders, particularly if distance or limited accommodation intervene. In some cases feelings of guilt are even greater when there is pressure to seek institutional solutions.

Some families, for a variety of reasons, including the legacies of their own families, are more vulnerable than others because:

(a) They are unable to meet the basic needs of their members for health, nutrition, shelter, physical and emotional care, and personal individual development;

(b) They experience physical or psychological exploitation or abuse of individual members, injustice in the distribution of rights and responsibilities or distortion of the roles of their members;

(c) They are subject to break-up as a consequence of external economic, social or political factors.

Large numbers of families can be considered at risk in a variety of circumstances owing to forces beyond their immediate control, particularly under circumstances of war, drought, famine, racial and ethnic violence, and economic deprivation. Labour migration provoked by poverty, single-parent families, refugee and displaced families, and those whose livelihoods have been destroyed by environmental degradation, are but a few examples of such families at risk. It would be desirable to identify the characteristics of families who are able to provide for the basic needs of their members in these circumstances in order to support and strengthen such characteristics and circumstances in other families.

Within populations of families who are providing for the basic needs of their members there are individual and groups of families that, for intra-familial reasons, lack the capacity to meet the basic needs of their members. These families may manifest a variety of problems, including domestic violence, drug and alcohol dependency, sexual and child abuse, and neglect. Until such time as the full pathology of these families becomes apparent, other public or voluntary institutions, if they and the resources exist, assume a greater responsibility for the family nurturing and caring functions.

Family functioning can be described at three levels:

(a) Families that function within the norms of their culture despite the stress of development and social change;

(b) Families that for whatever reason are vulnerable but have not yet manifested serious dysfunction and breakdown;

(c) Families in which the breakdown of function has already occurred.

In situations where this functional breakdown, affecting the health of the next generation and society at large, is already a reality, four main functions are threatened. First, the broad biological functions of protection and care. Next, the economic and social support functions of the family, then the educational and sociocultural functions concerned with the socialization of children and youth, and, finally, the psychological functions concerned with intra-family relationships and ties of affection.

The functions of the family most susceptible to disruption and most sensitive to the damaging effects of demographic, social, economic and technical change are not necessarily the most important for family survival. Thus disturbed relationships within the family, arguably of great importance in the long run, are less immediately catastrophic than are the effects of severe deprivation, inadequate economic resources, unemployment, hunger, isolation, forced displacement or serious disease. Each of these threatens the economic and protective functions of the family, which are vital to its immediate survival.

These major functions, like all those upon which family integrity and, thence in the long-term, societal integrity depends, are not distinct but are interrelated. Often the breakdown of family integrity is seen in terms of specific problems such as alcoholism or other substance abuse, mental illness, violence to women and child abuse, adolescent and unwanted pregnancies, and most recently AIDS. Strategic support from the community or State, if available, is usually problem-specific, yet to be most efficient and effective, it should be family- and system-oriented in its approach.

The consequences of functional breakdown will always be culture-specific but, at the individual level, they will have a very serious effect on children and the next generation. At worst this means inadequate socialization, a loss of ties of affection, dysfunctional or damaging relationships, and delinquent, authoritarian and violent behaviour. At the community level, violence and crime feature prominently with high non-specific morbidity, all with serious implications for an unhappy, insecure and angry society in future. But these are the crude effects of functional breakdown and it may be more accurate to assume that all aspects of the quality of family life are damaged when its normal function is much disturbed. Whatever the causal pathways are there is a clustering of factors in a relatively small proportion of families that renders them vulnerable to breakdown. A small proportion of vulnerable families break down and an even smaller proportion of them do so catastrophically. The effect on society of this small number of serious breakdowns is disproportionately large.

Families are vulnerable to dysfunction and breakdown for a variety of reasons, some of which can be predicted and prevented. The prevalence of vulnerable families in the population is rarely measured, partly because of the lack of suitable indicators and partly because of the compartmentalization of responses by individual sectors. Little is known about this type of family until such time as the problems begin to manifest themselves. If left undiagnosed and untreated, these highly vulnerable families would soon add considerably to the burden of suffering and cost to the community. If, following early diagnosis, effective intervention prevented further breakdown, the benefit would be considerable and disproportionate, all the more so if the interventions strengthened the families' capacity to deal with the immediate and subsequent problems.

Diagnosis of vulnerability to imminent breakdown presents a screening challenge. However, little is known of the accuracy (the specificity and sensitivity) of most screening tools, the predictive power of risk factors or the recovery rates with treatment. Several methods have been suggested but would require further evaluation in a variety of cultural settings. A number of research tools have been used to measure the functional capacity of families within larger population groups. Little is known, however, of the usefulness of family-oriented clinical tools to practising physicians. In one study, a large group of physicians engaged in a family practice were asked to rate the usefulness of 10 family-oriented tools. The respondents indicated a desire to develop their family counselling skills. Most family-oriented tools were reported to be useful but to be used infrequently by the practising physicians [16]. These and other tools have been examined as epidemiological tools in other settings [6, 25], but rarely as clinical instruments. At present many if not most of the tools that exist require special skills in their application and interpretation. Treatment of those families deemed to be at the edge of breakdown would at first be dictated by general considerations and the family's special needs, later by the success or failure of the care provided and the resources of the family.

In Sri Lanka a nine-item field instrument has been developed for use by community health workers to identify "families at risk" [22]. The items address the age of the mother; the number of children under the age of three years; the mother's/caretaker's knowledge of the child's needs and his/her responsiveness to health messages; whether the mother/caretaker is mentally disordered or severely depressed; whether he/she is neglectful of, or shows no interest in, the well-being/development of the child; cleanliness and organization of the home; whether the father is known to be delinquent, alcoholic or otherwise mentally disordered; presence of severe marital discord; and abject poverty.

The prevalence of the dysfunctional, damaged family is relatively low but its disintegration is usually long, costly and places a great burden on a wide range of available services. Intervention is rarely successful and much suffering results. At least one generation of children is without support and the effects are serious. Resource use is prodigal and disproportionate and the benefit-to-cost ratio of treatment is low. Effective prevention is preferred to the more costly and less effective therapeutic approaches to such families. First-aid measures in some developed countries involve special housing, sheltered accommodation for threatened wives and children, substantial money grants and the re-equipping and retaining of rehoused families. Much of the time of the social services is expended on repeated breakdowns.

There have been only a few long-term cohort studies of the generation-to-generation effects of family breakdown but these are not encouraging. Damage, particularly to children's and adolescent's mental health, and to their ability to form lasting relationships is reported. Consequently, countries that can afford it make special financial provision for long-term assistance. Once again, many sectors are involved and coordination is difficult. Legal commitments are lengthy and costly: most countries cannot afford them.

Among families subjected to almost impossible stresses such as war and extreme deprivation, there is almost always a small group of survivors who, against considerable odds, remain with their family functions damaged but not destroyed. A study of their material, psychological and other assets, their attitudes and the sources of their resilience would be as rewarding as the studies of risk factors for breakdown.

In spite of the stresses imposed by development and social change, most families function satisfactorily within the norms of their culture. For them, the objective of health promotion is to maintain this normality through the continued transfer of existing and new knowledge and skills for healthy lifestyles and self-care. These include such examples as: the promotion of healthy food and nutrition, including breast-feeding; oral health; avoidance of substance abuse, including tobacco; responsible sexual behaviour, as well as adequate orientation about sexuality for the young; exercise; personal hygiene; safety in the home; the use of simple and safe home-based remedies such as oral rehydration salts for diarrhoeal disease; and the appropriate and timely use of health services.

New participatory educational approaches will strengthen family resources and emphasize new responsibilities for self-care and family health behaviour. At the same time, a sensitive community takes what legislative, fiscal and programmatic steps it can afford to reduce external threats and increase family security; to effect supportive food, nutrition and health policies; and to facilitate the transfer to the family of the necessary coping and other skills. Priority would be given to those activities with the highest yield in cost and benefit terms. Thus, support for women, and security of food supply, living space and employment, the care and protection of children, promotion of healthy behaviour among adolescents, safe motherhood, family planning, universal literacy and, far less tangible but nearly as important, steps to encourage family membership of supportive neighbourhood and community groups would all have a high priority. Practical attempts by the educational sector to address the issue of health promotion and protection within families require changes in school curricula. Schoolchildren can become effective agents of health education within the family.

When families have been mobilized in support of health development, be it for health promotion, protection, care and rehabilitation, the focus has been on specific problems, often approached in an *ad hoc* or crisis management manner. Yet many of the problems faced are interrelated and could be dealt with by using a common set of skills and knowledge that are transferable to families. Access to information and communication and negotiation skills within families are key ingredients in child care, optimal functioning of the elderly, support of women's needs in the family, household food security, adolescent health, family planning and the role of men.

V. Implications of family health for national action

International instruments, such as the Convention on the Rights of the Child (General Assembly resolution 44/25) and the Convention on the Elimination of All Forms of Discrimination against Women (General Assembly resolution 34/180) are strongly supportive of the role and functions of the family. By ratifying such instruments, a country undertakes to meet the obligations embodied in them and must report regularly on the progress it is making in doing so. The Convention on the Elimination of All Forms of Discrimination against Women underlines the equal responsibilities of men and women in the context of family life.

The tasks in supporting families are formidable and challenging: for the individual family itself, for education, for social and fiscal policy, for local communities, for international agencies and institutions and for the health and social welfare systems. With these tasks comes the danger that attempted in isolation they will dissipate scarce resources and lose their multiplicative effect; a coordinated approach would raise both yield and understanding.

Unless the forces of change are too destructive to be resisted, families respond to challenge with surprising resilience and the essential functions of the family often survive the most intense assaults. Thus groups of abandoned street children sometimes care for their younger members as if they were in families. Local communities spontaneously look after their elderly and sick, supporting them emotionally as well as physically. Responsibilities that are universally recognized as those of the family seem to be readily assumed by most human groups, later to be incorporated into the culture before passing into national social policies and sometimes becoming laws. Paradoxically, when such actions create new institutions or mechanisms for care, which may be outside the structure or value system of the family, the family's capacity for effective functioning and support may be weakened.

When this happens the State is often accused of usurping the functions of the family to the detriment of all concerned, particularly children. To avoid such pitfalls, intervention by public or voluntary agencies, to the extent possible, should be designed so as not to make the family a passive recipient of care, but an active participant with due recognition and support being accorded to the functions of the family. Economic support and legal protection are two areas that can buttress the functions of the family. The integrity of the family is of such importance that its protection from catastrophe should, when affordable, become a normal responsibility of the State.

VI. Conclusion

The functions of the family have been described in relation to the six stages of the family life cycle: formation; extension; completed extension; contraction; completed contraction; and dissolution. Each phase of the family life cycle produces major family events and disturbances that are often of a severity that the health of one or other family member could be affected. Also altering family functions are changes in the roles and status of women: a new dynamic that is linked to longer education, literacy, the means to control fertility, and women's changing economic value and role. Families share a great deal more than their genes; their lifestyles, their intimate and extended environment, often their occupational environment, their diet and exercise patterns and nearly always their infecting and symbiotic organisms. Above all, they share their social environment, its vital roles and relationships, its pressures and pleasures, modes of conduct, value systems, sexual behaviour, mores and beliefs. The concept of vulnerable families should be recognized and defined within the health sector and intersectorally so that effective preventive action can be taken. Vulnerable families can be described as those that are likely to be unable to meet the basic needs of their members for health, nutrition, shelter, physical and emotional care, and personal individual development; to experience physical or psychological exploitation or abuse of individual members, injustice in the distribution of rights and responsibilities or distortion of the roles of its members; or to be subject to break-up as a consequence of external economic, social or political factors. In spite of the stresses imposed by development and social change, most families function satisfactorily within the norms of their culture. For them, the objective of health promotion is to maintain this normality through the continued transfer of existing and new knowledge and skills for healthy lifestyles and self-care.

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